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ABSTRACT

This report summarizes the results of a needs assessment of American Indians with disabilities living in the Houston and Dallas-Fort Worth (Texas) metropolitan areas. In 1996, 97 American Indians with disabilities were interviewed, and results were compared with those of a similar needs assessment conducted in 1992; 21 of the interviewees had participated in the earlier study. Demographic questions covered county of residence, sex, age, length of Texas residence, language usage, status of reservation or allotment area as home, tribal affiliation, tribal membership, marital status, education level, and income. Respondents then described their disabilities or chronic physical and medical conditions, assistive devices they needed, functional limitations they experienced, services they had received in the past year, services needed but not received, and barriers to receiving services. Important consumer concerns were then discussed. In Dallas-Fort Worth, the four greatest needs (20-36 percent of respondents) were for dental care, vision and eye care, housing, and medical care; in the prior study, the four greatest needs had been dental care, job-related services, housing, and clothing. The need for services was greater in Houston, where the greatest needs (26-43 percent of respondents) were vision and eye care, dental care, learning about services, and housing. Between the previous and the current study, consumer concerns had diminished in severity in Dallas-Fort Worth and remained about the same in Houston. Appendices describe the Texas Rehabilitation Commission's American Indian Project and contain a statement of Joellen Hores Simmons, Deputy Commissioner, Texas Rehabilitation Commission, April 24 and 29, 1996. Includes 23 data tables. (SV)

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Community Needs Assessments for the Texas Metropolitan Areas of Dallas–Ft. Worth and Houston: A Follow-up Study

Robert M. Schacht, Ph.D.

Rebecca Vanderbilt, B.A.

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Final Report

1997

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NORTHERN ARIZONA UNIVERSITY

Institute for Human Development
University Affiliated Program
PO Box 5630
Flagstaff, Arizona 86011

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Final Report
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American Indian Rehabilitation Research and Training Center
Institute for Human Development
University Affiliated Program
PO Box 5630
Flagstaff, Arizona 86011
(520) 523-4791

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This study could not have taken place without the cooperation of many people in Texas. The Texas Rehabilitation Commission (TRC) supported the project by providing funds for the local interviewers and stipends for the interviewees, as well as by authorizing and encouraging the participation, as needed, of state and local TRC personnel. In particular, the guidance and leadership of James L. Jackson, then executive deputy commissioner, was instrumental in initiating the original needs assessments in Dallas–Ft. Worth and Houston, and in supporting the follow-up studies in both metropolitan areas. We also appreciate the assistance of Joellen Simmons (Deputy Commissioner), J. Duarte (Program Specialist), Lori Kennedy (Osage; VR Counselor), Buena Henry (Area Manager), Arnold Barreira (Program Director), Larry Smith (Area Manager), and Royce Robinson (VR Counselor) in implementing this project.

Two local task forces served as project advisory councils; their participation was essential to the success of the project. In Houston, Larry Smith and Royce Robinson represented the TRC. Others included Walter Celestine (Alabama–Coushatta; JTPA), Deborah Scott (Cherokee; Cherokee Cultural Society), Paulette Greene (Choctaw; American Indian Chamber of Commerce), and Darwin Huff (Seneca; Intertribal Council of Houston). This group met on June 21, 1996 and selected Virginia Ferrell (Choctaw) to conduct the interviews.

In Dallas–Ft. Worth, the project advisory committee consisted of Lori Kennedy, Peggy Larney (Choctaw; Dallas Independent School District), Susann Longoria (ARC–Dallas), Dale Pfefferkorn (REACH–Dallas), Gary Kodaseet (Kiowa), and Frank McLemore (Cherokee). This group met on June

18, 1996, and discussed several candidates for interviewer. Lori Kennedy and Peggy Larney later interviewed three candidates and recommended Joe Bohanon (Choctaw) to conduct the interviews. Most members of both project advisory committees had participated in the original needs assessments.

In September, 1996, Joe Bohanon recruited Vicki Folsom, one of the interviewers for the original Dallas–Ft. Worth needs assessment, to help with the interviews in the Dallas area. In February, 1997, the Houston PAC reviewed the progress of the work and made several recommendations: (a) that more interviewers be recruited, (b) that the deadline for completing the interviews be extended, (c) that it was more important to have more time for interviews than to hold a community meeting at which the principal investigator personally would present the preliminary results of the project, and (d) that the community meeting could be held after funding for the project expired on March 25, 1997, without the presence of the principal investigator. Consequently, with the assistance of Deborah Scott acting as local research coordinator, a new interviewer, Lynette Starr (Cherokee) was recruited and trained. An interviewer for the original study, Otilia Sanchez (Yaqui) reviewed her training, and another interviewer from the original study, Jonathan Hook (Cherokee of Oklahoma) was recruited. With these additional interviewers, the deadline for interviews was extended to March 25, 1997.

This project would not have been possible without the cooperation of all of these people.

Community Needs Assessments for the Texas Metropolitan Areas of Dallas–Ft. Worth and Houston: A Follow-up Study

The Texas Rehabilitation Commission (TRC) held annual training conferences from 1988 to 1992 with community health representatives on the subject of American Indian people. Upon learning that the American Indian Rehabilitation Research and Training Center (AIRRTC) had conducted community-based needs assessments of American Indians with disabilities in Denver and Minneapolis–St. Paul (Marshall, Day-Davila, & Mackin, 1992; Marshall, Johnson, Martin, & Saravanabhavan, 1990/1993), Mr. James L. Jackson, then executive deputy commissioner of the Texas Rehabilitation Commission, requested in 1990 that we conduct a similar needs assessment in Dallas. The goal of this needs assessment, as defined at the 1991 staff conference in Dallas, was to increase through education the number of referrals, active cases, and rehabilitations by the TRC for American Indians with disabilities (Jackson, 1993). The scope was later expanded to include Ft. Worth. The needs assessment (Schacht, Hickman, Klibaner, & Jordan, 1993) made the following recommendations:

- Representatives of the organizations involved in the needs assessment (the TRC, the Dallas Intertribal Center [DIC], the American Indian Center, the Dallas Independent School District, the U.S. Administration on Aging, the Social Security Administration, the Dallas Indian United Methodist Church, and the Ft. Worth Indian Baptist Mission) should meet to

formulate a community action plan to develop strategies to meet the needs of American Indians with disabilities.

- The availability of general dental services at the Dallas Intertribal Center should be more effectively publicized.
- Employment services offered by the DIC and the TRC should be coordinated and publicized more effectively.
- An Indian Center is needed to coordinate services for American Indians in Tarrant County.
- Services are needed that are specifically targeted for young American Indians with disabilities, especially in the areas of (a) information and referral services, (b) quality treatment and prevention programs for alcohol and substance abuse, (c) career counseling, (d) special programs to help make the transition from public school to employment and community living, and (e) improved safety and accessibility of public transit systems.
- The American Indian media should be utilized more fully (e.g., Indian programs on radio and TV, newsletters, newspapers, information tables, announcements at pow-wows, etc.)
- Improvements are needed in the availability and affordability of assistive devices.

Mr. Jackson, on behalf of the TRC, then asked us to conduct a similar needs assessment in the Houston metropolitan area. Consequently, in 1993, a team of 13 Native American interviewers interviewed 155 Native Americans with disabilities in seven counties in southeast Texas in the vicinity of Harris County (Schacht, Morris & Gaseoma, 1993). The Houston needs assessment made several recommendations:

- An eye/vision clinic is needed at the Inter-Tribal Council of Houston (ITCH) one or two days per week.
- A mental health clinic is needed at the ITCH one or two days per week.
- Vocational rehabilitation and job counseling services should be continued weekly at regularly scheduled times at the ITCH.
- A public advocacy position is needed at the ITCH.

These two needs assessments constituted Phase I of a two phase plan. The second phase in each metropolitan area was to be a follow-up study.

The present study (Phase II) was designed to find out what impact the original assessments had and whether services to American Indians with disabilities had improved. Specifically, this study was designed to investigate possible changes in consumer concerns that were rated most important and least satisfactory ("relative problems").

METHODOLOGY

The needs assessment for this follow-up study used essentially the same questionnaires as the original studies in 1992–1993, except that most open-ended questions were omitted because systematic comparison of such questions would be too difficult. The questionnaires included a broad range of questions on consumer demographics, disability, experience with services, concerns, employment history, and so on. The questionnaires differed mainly in the Consumer Concerns section, which consisted of items developed by consumer focus groups in both areas.

These focus groups consisted of American Indians residing in Dallas–Ft. Worth and Houston. Most of them had a disability or had a family member with a disability. Previous community-based needs assessments of American Indians with disabilities that had taken place in Denver and Minneapolis–St.

Paul had generated a list of items identified by American Indian consumers in those cities; the Texas focus groups had access to these items, as well as items developed in previous needs assessments that had used the Consumer Concerns method (Fawcett, Suarez de Balcazar, Johnson, Whang-Ramos, Seekins, & Bradford, 1987; Fawcett, Suarez de Balcazar, Whang-Ramos, Seekins, Bradford, & Mathews, 1988). The Consumer Concerns method refers to these focus groups as "working groups." The purpose of the working groups was to develop the consumer concerns items to be used in the needs assessment. Each item had two characteristics: It was stated in the positive, and it used second-person singular ("you"). The purpose of this format was to facilitate a comparison of the results for each item. The Texas working groups were given these guidelines:

1. They were to pick the 30 to 40 items they thought were most important to American Indians with disabilities in their metropolitan area.
2. They could choose items from previous Consumer Concerns studies.
3. They could modify any item from a previous Consumer Concerns study.
4. They could create new items not in previous studies.

This process was described in greater detail in the original (Phase I) study (Schacht, Hickman, Klibaner & Jordan, 1993, pp. 10–11). Working groups in Dallas–Ft. Worth developed the consumer concerns to be used in that metroplex, and another working group in Houston developed the consumer concerns used there.

Interviews were conducted in person by American Indian interviewers who had been trained by the principal investigator. The target population included American Indians who had already been interviewed in 1992 and 1993 (Phase I), and other American Indians with disabilities recruited by the

interviewers who had been living in the metropolitan areas since before 1993. A mailing list of previous interviewees was used as a starting point in both metropolitan areas.

The interviews took place at a mutually convenient location, often in the home of the interviewer. Questions were read aloud by the interviewer, and the interviewees' oral responses were then recorded. Some questions required flash cards to help the interviewee select from a list of response choices. Each interview took about an hour to complete.

RESULTS

This report summarizes the follow-up (Phase II) study for the Dallas–Ft. Worth and Houston metropolitan areas. Results from the original (Phase I) studies in these metropolitan areas (Schacht, Hickman, Klibaner, & Jordan, 1993; Schacht, Morris, & Gaseoma, 1993) are included for comparison purposes.

Tables 1 through 15 report general demographic characteristics of the original and follow-up samples. If the Phase I and Phase II samples are both unbiased representatives of the target population, then the results from both phases should be very similar for Tables 1 through 15, unless the target population itself changed in some fundamental way between the original study and the follow-up.

One purpose of this follow-up study was to identify possible changes in the delivery of services to American Indians with disabilities following the original needs assessment. Results from Phases I and II are presented side by side to facilitate comparison. Tables 16–23 should therefore show *differences* between Phases I and II in areas where the community has responded positively to the recommendations of the original study. The tables also

contrast results from the Dallas–Ft. Worth and Houston metropolitan areas to reveal statewide patterns (when the results are similar) and regional differences (when the results are not similar).

Samples

During Phase I of the study in 1992, 150 American Indians with disabilities were interviewed in Dallas and Ft. Worth. During Phase II in 1996, 44 were interviewed. Of these, 21 (48%) reported that they had been interviewed for the original survey (Table 1). Four of these Phase II interviewees were not sure if they had been interviewed in 1992; they were included among the 23 "Only Phase II" interviewees in Table 1.

In the Houston metropolitan area, 155 American Indians with disabilities were interviewed for the Phase I study. Fifty-three American Indians with disabilities were interviewed for the Phase II study; of these, 7 (13%) reported that they had been interviewed in Phase I. The Phase II interviews were conducted between August, 1996 and March 1997. An additional three Phase II interviewees (6%) were not sure if they had been interviewed previously; they were included in the "Only Phase II" category (see Table 1).

Most Phase I and II interviewees from the Dallas–Ft. Worth metroplex resided in either Dallas or Tarrant County (Table 2). Only one participant in the Phase II study lived elsewhere (Wise County). Of the 10 participants in the Phase I study who lived elsewhere, 2 resided in other Texas counties and 8 were from Oklahoma or New Mexico.

Table 1

Interviews in Phase I and II, by Metro Area

Metro Area	Only Phase I	Both Phase I and II	Only Phase II	Total
Dallas–Ft. Worth	129	21	23	183
Houston	148	7	46	201
Total	287	28	69	384

Table 2

County of Residence, Dallas–Ft. Worth

	Phase I		Phase II	
	n	%	n	%
Dallas	114	76%	30	68%
Tarrant	26	17%	13	30%
Other	10	7%	1	2%
Total	150	100%	44	100%

Table 3 presents the counties of residence for interviewees in the Houston metro area. In Phase I, most interviewees were from Harris County. In Phase II, many respondents were also from Brazoria County. Polk, Ft. Bend, Montgomery, and Galveston Counties were represented in both samples as well.

Table 3

County of Residence,

Houston Metropolitan Area

	Phase I		Phase II	
	n	%	n	%
Harris	124	80%	20	38%
Brazoria	2	1%	19	36%
Polk	9	6%	8	15%
Fort Bend	2	1%	2	4%
Waller	—		2	4%
Montgomery	14	9%	1	2%
Galveston	1	1%	1	2%
Jefferson	3	2%	—	
Total	155	100%	53	100%

Sex

The Phase I sample in Dallas–Ft. Worth was almost evenly split between males and females (see Table 4). The other samples had more females than males.

Age

In the Dallas–Ft. Worth sample, the average age of the Phase I sample was 42, with a range of 7 to 81. Most of those respondents (61%) were 30 to 54 years of age. In comparison, the average age of respondents in the Phase II

Table 4

Sex of Interviewees

	Dallas–Ft. Worth				Houston			
	Phase I		Phase II		Phase I		Phase II	
Sex	n	%	n	%	n	%	n	%
Male	73	49%	14	32%	63	41%	23	43%
Female	77	51%	30	68%	92	59%	30	57%
Total	150	100%	44	100%	155	100%	53	100%

study was 46 years, with a range of 12 to 74. Nearly half (n = 21) were in their 40s (see Table 5).

The Houston Phase I sample included more adolescents. Respondents ranged in age from 9 to 75; 90% (n = 139) were between 17 and 63 years of age. The average age was 39. Phase II respondents from Houston ranged in age from 16 to 78 years, with an average age of 43. Age was not reported for one (2%) respondent. Only 4% (n = 2) were younger than 21, and 87% (n = 46) were between 21 and 63 years of age.

Length of Residence

In the Phase I Dallas–Ft. Worth sample, most of the 150 interviewees had lived in Texas for at least 10 years; 18 (12%) had lived there for less than a year. All of those interviewed for the Phase II follow-up study reported having lived in Texas for at least a year; the average length of residence was 27 years (see Table 6).

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Table 5 Average Age		
Metro Area	**Phase I**	**Phase II**
Dallas–Ft. Worth	42 (7–81)	46 (12–74)
Houston	39 (9–75)	43 (16–78)

In the Phase I Houston sample, the average length of residence was 21 years; only 10% (n = 15) had lived in the Houston area for 44 years or more. In the Phase II Houston sample, the average length of residence in southeast Texas was 28 years. Fifteen percent (n = 8) had lived there 9 years or less, 19% (n = 10) had lived there between 12 and 20 years, and 19% (n = 10) had lived there between 21 and 30 years. Nearly half had been there more than 30 years: 21% (n = 11) between 31 and 40 years, and 26% (n = 14) more than 40 years.

Table 6 Average (Maximum) Length of Residence		
Metro Area	**Phase I**	**Phase II**
Dallas–Ft. Worth	20 (45)	27 (49)
Houston	21 (70)	28 (60)

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Language Usage

Respondents were asked several questions about their language usage. In both project phases, respondents were asked, "What language is spoken most in your home?" At least three of every four respondents in both metropolitan areas reported that English was spoken most in their home (Table 7). Up to 18% used both English and their tribal language at home. They were also asked what language they preferred service providers to use; most preferred English. The Phase I respondents were also asked, "Can you speak English fluently (enough to carry on a conversation)?" Of the Phase I sample in Dallas–Ft. Worth, only six respondents (4%) did not speak English fluently. They were also asked if they spoke a tribal language fluently. In Dallas–Ft. Worth, 37% said yes; in the Houston metropolitan area, only 10% said yes (Table 7).

In the Houston Phase II sample, two respondents (4%) mostly spoke Spanish in their home. Most respondents (83%; n = 44) preferred that service providers speak English; the remainder preferred either tribal language (8%; n = 4), tribal language with English (8%; n = 4), or Spanish (2%; n = 1).

Reservation Preferences

Respondents in the Dallas–Ft. Worth metroplex were asked if there was a reservation that they considered home. Of those interviewed in the Phase II study, 15 (34%) said yes (Table 8). Half of the respondents said they visited a reservation; for most of these the frequency of visits was between one and six times per year. This information was not available for Phase I in the Dallas–Ft. Worth area.

Table 7

Language Use

	Dallas–Ft. Worth				Houston Metro Area			
	Phase I N = 150		Phase II N = 44		Phase I N = 155		Phase II N = 53	
Language Use	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Mostly speak English at home	124	83%	35	79%	148	95%	43	81%
Speak English fluently	144	96%	—		148	95%	—	
Mostly speak English & tribal language at home	19	13%	8	18%	2	1%	6	11%
Mostly speak tribal language at home	4	3%	—		3	2%	2	4%
Speak tribal language fluently	59	39%	—		15	10%	—	
Prefer service providers use:								
English	131	87%	34	77%	149	96%	44	83%
Tribal language	3	2%	4	9%	2	1%	4	8%
Both	13	9%	3	7%	2	1%	4	8%

When respondents of the Phase I survey in the Houston metropolitan area were asked if there was a reservation or tribal allotment area that they considered home, 22% (n = 34) said there was a reservation area that they considered home. Most of these, 16% of the whole sample (n = 25), visited there at least once a year (some visited up to twice a week). Four respondents (3%) lived on a reservation (Table 8). When asked if they would live on a reservation if needed services were provided there, 59% (n = 92) said yes. In the Houston Phase II survey, 36% (n = 19) of the respondents said yes (Table 8). Three respondents (6%) either lived on a reservation or visited

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Table 8

Reservation Preferences

	Dallas–Ft. Worth		Houston Metro Area			
	Phase II N = 44		Phase I N = 155		Phase II N = 53	
	n	%	n	%	n	%
Reservation or allotment area considered home?	15	34%	34	22%	19	36%
Live there	—		4	3%	2	4%
Visit at least 2–3 times a year	15	34%	14	9%	4	8%
Visit about once a year	5	11%	11	7%	5	9%
Visit less than once a year	2	4%	6	4%	8	15%
Subtotal - Ever visited	22	50%	35	23%	19	36%

every day. Nine more (17%) said they visited a reservation area at least once (and up to six times) per year. Eight others (15%) very rarely visited (between every 2 years, and last visit more than 10 years ago). When asked if they would live on a reservation if needed services were provided there, 75% (n = 40) said yes.

Tribal Affiliation

The most frequent tribal identification in the Dallas–Ft. Worth area was Choctaw, with 51 (34%) identifying themselves as such in Phase I. The same was true in Phase II, when 17 interviewees (39%) identified themselves as Choctaw. Nearly a quarter of each sample reported having mixed Indian ancestry. See Table 9 for a complete list of tribal affiliations of participants.

Cherokee was the most frequent identification in both Houston phases. In Phase I, 34% (n = 53) reported being Cherokee, compared with 38% (n = 20)

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in Phase II. A mixed Cherokee ancestry was also frequently reported in both Houston phases. See Table 9 for a complete list of tribal affiliations of participants.

Table 9

Tribal Affiliation

	Dallas–Ft. Worth				Houston			
	Phase I		Phase II		Phase I		Phase II	
Tribal Affiliation	n	%	n	%	n	%	n	%
Choctaw	51	34%	17	39%	9	6%	4	8%
Cherokee	11	7%	2	4%	53	34%	20	38%
Cherokee (mixed ancestry)	4	3%	—		19	12%	5	9%
Alabama–Coushatta, Alabama, Coushatta, or Alabama–Comanche	1	<1%	—		14	9%	5	9%
Navajo	9	6%	—		1	<1%	2	4%
Comanche	9	6%	—		4	3%	1	2%
Sioux	7	5%	1	2%	1	<1%	2	4%
Kiowa	6	4%	1	2%	1	<1%	—	
Chippewa	1	<1%	1	2%	6	4%	—	
Potawatomi	—		—		5	3%	—	
Yaqui, Yaqui/ Comanche	—		—		4	3%	—	
Creek (Muscogee)	5	3%	4	9%	3	2%	—	
Chickasaw	1	<1%	—		3	2%	1	2%
Apache	3	2%	—		2	1%	4	8%
Arapaho	3	2%	—		—		—	
Ponca	3	2%	3	7%	1	<1%	—	
Seminole	2	1%	2	4%	—		—	
Iroquois	—		—		3	2%	—	
Mixed tribal ancestry	29	19%	10	23%	5	3%	—	
Unknown	—		1	2%	—		2	4%
Other tribes	5	3%	2	4%	21	14%	7	13%
Total	150	99%	44	99%	155	99%	53	101%

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Tribal Identification

Respondents were asked if they had a Certificate of Degree of Indian Blood (CDIB) card, tribal identification card, roll number, or tribal membership card. In general, respondents from the Houston metropolitan area said yes only about half as often as in the Dallas–Ft. Worth metroplex (see Table 10).

Marital Status

Most respondents in all four samples were married. In Dallas–Ft. Worth, 21 (14%) in Phase I reported "other" status, compared with only 3 (7%) in Phase II. This question provided a blank space for respondents to explain "other" status. Most of these respondents reported being separated, but others listed single, official, or common-law. Respondents in the Houston metro area, Phase II, reported the highest divorce rate and the lowest rate of persons never married.

Table 10

Tribal Identification

CDIB, Tribal ID, Roll Number, or Tribal Membership	Phase I		Phase II	
	n	%	n	%
Dallas–Ft. Worth Metroplex	129	86%	38	86%
Houston Metropolitan area	59	38%	23	43%
Total	188	62%	61	63%

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Table 11

Marital Status

	Dallas–Ft. Worth				Houston			
	Phase I		Phase II		Phase I		Phase II	
Status	n	%	n	%	n	%	n	%
Never married	31	21%	9	21%	42	27%	9	17%
Married	58	39%	22	50%	63	41%	22	42%
Divorced	29	19%	7	16%	40	26%	18	34%
Widowed	11	7%	3	7%	7	5%	2	4%
Other	21	14%	3	7%	3	2%	2	4%
Total	150	100%	44	100%	155	101%	53	101%

Education Level

Table 12 presents the highest educational level obtained for respondents in the two metropolitan areas. The percentage of Dallas–Ft. Worth Phase I respondents who had less than a high school education was much higher (31%) than any of the other samples (18% or less). This may be related to the relatively high percentage in that sample with very low incomes (see Table 13). The largest percentage with a high school diploma (45%) was from the Phase II Dallas–Ft. Worth sample. The largest percentage with a trade or vocational school certificate was the Phase II sample from Houston (25%). The largest percentage with some college education, including an AA, bachelor's, master's, or doctor's degree was the Houston Phase II sample (36%).

In the Phase I sample, 52% (n = 78) of the respondents from Dallas–Ft. Worth believed that their education had prepared them for work, compared with only 36% (n = 56) of the respondents from the Houston metropolitan area Phase I sample. When the Houston Phase II respondents were asked if they felt education had prepared them for work, 55% (n = 29) said yes. When Houston respondents were asked if they had been in a special education class or resource room at any time during kindergarten through 12th grade, 28% (n = 15) of the Phase II sample said yes. In the Phase I sample, 15% (n = 24) had been in a special education class at some point.

Table 12

Education Level

	Dallas–Ft. Worth				Houston			
	Phase I		Phase II		Phase I		Phase II	
	n	%	n	%	n	%	n	%
Less than high school	46	31%	8	18%	28	18%	6	11%
High school diploma	29	19%	20	45%	54	35%	11	21%
GED	16	11%	3	7%	19	12%	3	6%
Trade or vocational school certificate	9	6%	6	14%	17	11%	13	25%
Some college	38	25%	3	7%	5	3%	1	2%
AA degree	7	5%	3	7%	8	5%	10	19%
Bachelor's degree	1	<1%	1	2%	12	8%	3	6%
Master's/Doctor's	1	<1%	—		8	5%	5	9%
Other	—		—		4	3%	1	2%
Total	147	99%	44	100%	155	100%	53	101%

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Income

The monthly family income of respondents is presented in Table 13. Respondents were asked to include all sources of income. Some people did not answer this question, so the total n is smaller for each column, and the percentages add up to less than 100%. The most striking difference is the

Table 13

Monthly Family Income

	Dallas–Ft. Worth				Houston			
	Phase I N = 150		Phase II N = 44		Phase I N = 155		Phase II N = 53	
	n	%	n	%	n	%	n	%
$0–199	24	16%	2	5%	6	4%	3	6%
$200–399	3	2%	1	2%	11	7%	—	
$400–599	3	2%	1	2%	8	5%	4	8%
$600–799	—		4	9%	4	3%	1	2%
$800–999	2	1%	5	11%	14	9%	3	6%
$1000–1199	—		8	18%	17	11%	7	13%
$1200–1399	6	4%	2	5%	10	7%	6	11%
$1400–1599	3	2%	2	5%	16	11%	3	6%
$1600 or more	102	68%	[15]	[34%]	[51]	[34%]	[22]	[42%]
$1600–1799	—		1	2%	9	6%	3	6%
$1800–1999	—		4	9%	8	5%	4	8%
$2000 or more	—		10	23%	34	23%	15	28%
Total	143	95%	40	91%	137	88%	49	92%

relatively large number of low income (less than $200 per month) and higher income ($1600 or more per month) respondents in Phase I of the Dallas–Ft. Worth needs assessment.

Reported Disabilities

In the focus groups and in the interviews, many people were not familiar with the term *disability*. Consequently, respondents were asked for disability-related information in several different ways. First, respondents were asked to describe their disabilities or chronic physical and medical conditions. Then they were asked what assistive devices they needed, and then what functional limitations they experienced. The purpose of these questions was not just to learn what conditions had been diagnosed or were severe enough to be considered a primary or substantial disability, but to learn what conditions they experienced and felt to be problems for themselves. Therefore, the conditions listed in Table 14 do not necessarily reflect conditions for which respondents are identified as disabled (for the purpose of vocational rehabilitation, or collecting SSI or SSDI, for example). Additionally, many respondents reported more than one condition. Table 14 lists conditions in descending order of their combined prevalence in the samples.

Disability was determined with more detailed questioning in Phase I of the Dallas–Ft. Worth study, where the interviewer recorded whether a condition was the primary disability, or an "other" disabling condition of either major or minor severity. For this report, responses to a number of questions were combined for some disabling conditions. For example, if a respondent said that they had a visual impairment, glaucoma, or were blind, or if they wore or needed eyeglasses, or if they said their disability limited them in reading or seeing, the total number with visual impairment or low vision (counting each person only once) was 71% of the sample (Schacht, et

al., 1993, p. 24). But when asked only to describe their disability, just 34% mentioned visual impairment or glaucoma (Table 14). Even so, visual impairment or glaucoma was the most common disability in the Houston metropolitan area, and was among the top three disabilities in the Dallas–Ft. Worth metroplex.

Similarly, if asked only to describe their disability, 11% of the Dallas–Ft. Worth Phase I sample mentioned an "orthopedic disorder." However, if among these are included those who said they had an amputation, spinal cord disorder, multiple sclerosis, stroke, or polio, or use or need a cane, a wheelchair, a walker, or a prosthesis, or those who said their disability limited them in using their limbs, walking, sitting, lifting, or manual tasks, the combined total (counting each person only once) was 61% (Schacht, et al., 1993, p. 26).

Additionally, multiple major disabilities were reported by 9% (n = 13) of the Phase I respondents from Dallas–Ft. Worth. This information is not available for the Phase II sample. The categories of skin diseases, anxiety, and eating disorders were not explicitly included in both questionnaires. These differences should be kept in mind when making comparisons from Table 14, especially on the "Average" and "Total" rows. Nevertheless, these totals show that on the average, each respondent reported two to three disabilities.

Table 14

Reported Disabilities

	Dallas–Ft. Worth				Houston			
	Phase I N = 150		Phase II N = 44		Phase I N = 155		Phase II N = 53	
Condition	n	%	n	%	n	%	n	%
Visual impairment or glaucoma	52	34%	8	18%	44	28%	17	32%
Diabetes	57	38%	17	39%	20	13%	8	15%
Arthritis	31	21%	15	34%	33	21%	19	36%
Hypertension	43	29%	8	18%	26	17%	12	23%
Substance abuse	33	22%	5	11%	32	21%	6	11%
Hearing impairment or deaf	28	19%	5	11%	23	15%	9	17%
Orthopedic disorder	17	11%	7	16%	22	14%	19	36%
Anxiety			2	5%	34	22%	12	23%
Heart problems	19	13%	6	14%	13	8%	7	13%
Depression	10	7%	1	2%	22	14%	9	17%
Specific learning disability	4	3%	2	5%	17	11%	8	15%
Neurological impairment	10	7%	6	14%	7	5%	7	13%
Personality disorder	4	3%	1	2%	20	13%	1	2%
Lung disorder	7	5%	1	2%	9	6%	7	13%
Spinal cord disorder	3	2%	2	5%	8	5%	7	13%
Eating disorder	7	5%	—		10	6%	—	
Cancer	4	3%	2	5%	6	4%	4	8%
Kidney disorder	4	3%	1	2%	8	5%	2	4%
Asthma	7	5%	1	2%	6	4%		
Multiple major disabilities	13	9%	—		—		—	
Stroke	5	3%	3	7%	2	1%	1	2%
Epilepsy	4	3%	—		3	2%	4	8%
Bipolar disorder	3	2%	3	7%	2	1%	1	2%
Traumatic brain injury	2	1%	2	5%	4	3%	1	2%
Amputation	5	3%	—		3	2%	—	
Skin diseases	5	3%	—		—		—	
Muscular disease	1	<1%	2	5%	—		2	4%
Mental retardation	3	2%	—		—		—	
Schizophrenia	—		1	2%	1	<1%	—	
Total	381		101		375		163	
Average	2.54		2.29		2.42		3.05	

Functional Limitations

Limitations reported by both groups are presented in Table 15, which lists these limitations in descending order of their combined frequency. After the Phase I needs assessment in Dallas–Ft. Worth, several new categories of limitations were added to the subsequent needs assessments (i.e., the Houston Phase I interviews and the Phase II interviews in both metropolitan areas): limitations in standing, driving, getting along with people, and using public transportation. Limitations in breathing were only included in the Phase I studies. Limitations in sleeping were explicitly included only in the Houston Phase I study; sleeping was mentioned by one person under "other" in the Dallas–Ft. Worth Phase I study. The large number of those indicating sleeping difficulties in Houston Phase I indicates that an expanded follow-up is warranted to find out if these limitations are due to the disability or to some other factor.

The respondents from Houston, in both phases, indicated an average of more than seven limitations per person, a much higher rate than for either phase of the Dallas–Ft. Worth studies. This may indicate poorer health care services in Houston, overall, than in the Dallas–Ft. Worth area, which might in turn be related to the lack of an IHS clinic in Houston.

Table 15

Disability Limitations

DI-2. Does your disability limit you in:	Dallas–Ft. Worth				Houston			
	Phase I N = 150		Phase II N = 44		Phase I N = 155		Phase II N = 53	
	n	%	n	%	n	%	n	%
Working on a job (e.g., full-time, not missing work)	69	46%	18	18%	76	49%	25	47%
Walking	55	36%	21	21%	68	44%	31	58%
Lifting	49	32%	24	54%	71	46%	30	57%
Seeing	51	34%	13	30%	63	41%	30	57%
Driving			14	32%	63	41%	17	32%
Remembering	51	34%	19	43%	60	39%	25	47%
Reading	44	29%	15	34%	61	39%	27	51%
Performing manual tasks	46	31%	18	41%	71	46%	28	53%
Use of arms	33	22%	16	36%	47	30%	19	36%
Use of hands	32	21%	18	41%	47	30%	24	45%
Self-care (e.g., dressing, bathing, shopping, cooking, etc.)	24	16%	10	23%	32	21%	14	26%
Writing	26	17%	14	32%	49	32%	19	36%
Sitting	18	12%	11	25%	47	30%	21	40%
Having a sexual relationship	21	14%	9	21%	42	27%	14	26%
Hearing	28	18%	7	16%	28	18%	12	23%
Learning	21	14%	9	21%	41	27%	14	26%
Getting along with people	—		8	18%	44	28%	9	17%
Speaking	24	16%	8	18%	34	22%	7	13%
Using public transportation	—		7	16%	23	15%	10	19%
Standing	—		19	43%	62	40%	30	57%
Sleeping	1*	<1%	—		80	52%	—	
Breathing	29	19%	—		37	24%	—	
Ability to work in places with access to controlled substances	—		—		32	21%	—	
Other	4	<3%	3	7%	28	18%	4	8%
Total	625	4.15	281	5.90	1206	7.80	410	7.74

*Category was not listed in questionnaire. [One respondent wrote this in under "other"].

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Services Information

Respondents were asked a series of questions about what services they had received during the past year from agencies that serve people with disabilities. They were also asked why they may not have received some of the services they needed or wanted. Tables 16 and 17 present what services were needed but not received by the respondents in both metropolitan areas.

Table 16 presents the services that were needed but not received by the respondents in the Dallas–Ft. Worth metroplex. Dental care was the service needed most by respondents in both phases. In Phase I, 33% (n = 50) needed dental care, compared with 36% (n = 16) of the Phase II sample. Another similar level of need between the two samples was the need for finding adequate housing. Of the Phase I sample, 23% (n = 35) needed such help, compared with 20% (n = 9) of the Phase II sample.

More respondents in the Phase I sample (29%; n = 43) needed job-related services. They also reported needing help receiving clothing (22%; n = 33), and help receiving food (18%; n = 27).

In the Phase II study, respondents also reported needing vision and eye care (30%; n = 13), medical care (20%; n = 9), and help getting a job or job training (14%; n = 6).

For each service, the barrier most often identified by respondents is listed. For many services, respondents most frequently noted that either they didn't know about the services or the services were never offered to them.

Table 16

Services Needed in the Past Year but Not Received, Dallas–Ft. Worth

Services Needed but Not Received			Barrier Most Frequently Identified (and times mentioned)	
	n	%	n	
Dental care				
Phase I	50	33%	18	Could not afford the service
Phase II	16	36%	7	Didn't know about the service
Help getting or keeping a job, including training				
Phase I	43	29%	23	Services were not offered
Phase II	7	16%	5	Providers not helpful/services not offered
Help receiving housing				
Phase I	35	23%	18	Services were not offered
Phase II	9	20%	5	Didn't know about the service
Help receiving clothing				
Phase I	33	22%	18	Services were not offered
Phase II	6	14%	3	Didn't know about the service
Help receiving food				
Phase I	27	18%	11	Services were not offered
Phase II	4	9%	1	Services were not offered
Help applying for benefits like SSI or food stamps				
Phase I	22	15%	9	Services were not offered
Phase II	6	14%	1	Didn't know about the service
Receiving help (i.e., learning of services)				
Phase I	21	14%	15	Services were not offered
Phase II	5	11%	4	Service provider was not helpful
Medical care				
Phase I	16	11%	7	Services were not offered
Phase II	9	20%	3	Services were not offered
Helping with daily living skills				
Phase I	17	11%	6	Didn't know about the service
Phase II	1	2%	1	Didn't know about the service

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Table 16

Services Needed in the Past Year but Not Received, Dallas–Ft. Worth

(continued)

Services Needed but Not Received			Barrier most frequently identified (and times mentioned)	
	n	%	n	
Learning to use public transportation				
Phase I	10	7%	4	Didn't know about the service
Phase II	2	5%	2	Didn't know about the service
Vision and eye care				
Phase I	—		—	
Phase II	13	30%	6	Didn't know about the service

Table 17 presents the services that were needed but not received by the respondents in the Houston metropolitan area. In the Phase I sample, nearly half needed but were not receiving dental care (48%; n = 75). Many also needed vision and eye care (42%; n = 65) and help learning about services (36%; n = 56). Needing help getting a job or job training was reported by 33% (n = 51), much higher than the Phase II sample (17%; n = 9). The needs of the Phase II sample were mostly very similar. Respondents especially needed vision and eye care that they were not receiving (43%; n = 23). Dental care was also mentioned frequently (36%; n = 19).

In both samples, respondents often cited the reason for not receiving services as not knowing about it, especially for their greatest needs. In the

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Table 17

Services Needed in the Past Year but Not Received, Houston Metropolitan Area

Services Needed but Not Received			Barrier Most Frequently Identified (and times mentioned)	
	n	%	n	
Vision and eye care				
Phase I	65	42%	37	Could not afford the service
Phase II	23	43%	6	Didn't know about the service
Dental care				
Phase I	75	48%	36	Didn't know about the service
Phase II	19	36%	7	Could not afford the service
Receiving help (e.g., learning of services)				
Phase I	56	36%	35	Didn't know about the service
Phase II	17	32%	12	Didn't know about the service
Help receiving housing				
Phase I	38	25%	25	Didn't know about the service
Phase II	14	26%	6	Didn't know about the service
Help getting or keeping a job, including training				
Phase I	51	33%	30	Didn't know about the service
Phase II	9	17%	2	Services were not offered
Help receiving clothing				
Phase I	28	18%	23	Didn't know about the service
Phase II	11	21%	8	Didn't know about the service
Medical care				
Phase I	36	23%	24	Didn't know about the service
Phase II	8	15%	4	Services were not offered
Help receiving food				
Phase I	27	17%	13	Didn't know about the service
Phase II	9	17%	5	Didn't know about the service
Help applying for benefits like SSI or food stamps				
Phase I	27	17%	13 13	Didn't know about the service /Services were not offered
Phase II	7	13%	4	Services were not offered

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Table 17

Services Needed in the Past Year but Not Received, Houston Metropolitan Area

(continued)

Services Needed but Not Received			Barrier Most Frequently Identified (and times mentioned)	
	n	%	n	
Learning to use public transportation				
Phase I	7	5%	3	Didn't know about the service
Phase II	3	6%	1/1	Didn't know/not offered
Help with daily living skills				
Phase I	5	3%	4	Didn't know about the service
Phase II	2	4%	1/1	Didn't know/not offered

Phase I sample, the most frequent barrier to receiving vision care was that the respondents could not afford the service. Cost was also often mentioned in the Phase II sample as a barrier to dental care. It is possible that these respondents were simply stating that they didn't use these services because they were too expensive. Respondents in both samples who said they didn't know about medical/dental services might have meant that they didn't know that they could receive financial help for such services. For several other services, such as medical care and job training, respondents in the Phase II sample were more likely to say that services were not offered to them, rather than that they didn't know about them, as many in the Phase I sample said. This may indicate that the Phase II respondents were more aware of various services (i.e., through friends, media, other people receiving them, etc.), but were unsure of how one qualifies or receives services, and did not know where to find out.

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Current Services

Respondents were also asked which services, from any agency, they currently use or have used in the past year. This information is presented in Table 18, in descending order of frequency of use. Private medical doctors were the primary source of services received except in the Phase I sample from Dallas–Ft. Worth—which is precisely the sample with the highest use of an Indian Health Agency. These observations may be linked because (a) there was an IHS clinic in the Dallas Intertribal Center and (b) the Phase I sample from Dallas–Ft. Worth included the largest percentage of respondents with very low family incomes (Table 13). Probably because of the IHS clinic in Dallas, the frequency of using an Indian Health Agency is much higher in that metroplex (34–40%) than in Houston, where there is no IHS clinic (7–13%). The nearest Indian Health Agency to Houston is the one on the Alabama–Coushatta reservation on the northern edge of the survey region, 75 miles north of Houston. Similarly, respondents from Dallas–Ft. Worth reported using services from an Indian Center (18–38%), probably referring to the Dallas Intertribal Center or the American Indian Center, much more frequently than respondents in the Houston metropolitan area, where only one intertribal center was struggling to become established during Phase I (3%), but which had lost its facility by the time of Phase II (0%). The relatively high frequency of contact with an eye doctor in the Houston metropolitan area (27–36%) may be due to the outreach efforts of Dr. Jerald Strickland's program at the University of Houston's College of Optometry, and the lack of such efforts in the Dallas–Ft. Worth metroplex. As a result of the Phase I study in Houston, a one-year letter of understanding between the College of Optometry and the Intertribal Council of Houston was written to facilitate eye

care. It may be that the increase in contact with eye doctors reported by respondents in Houston Phase II reflects the impact of this outreach effort.

In both metropolitan areas, services for alcohol or substance abuse counseling declined from 12–15% among Phase I respondents to 5–6% among Phase II respondents. The percentage of respondents reporting current vocational rehabilitation services increased from 4% to 9% among respondents from Dallas–Ft. Worth, but the percentage actually decreased (by a probably insignificant amount) in Houston. This difference might be related to continuity of American Indian personnel in the Dallas VR office, compared with changes in American Indian personnel in the Houston region.

The Phase II sample was not asked about city health clinics, psychologists, or the state's Developmental Disabilities department.

Consumer Concerns

Consumer concerns were identified by the previously described working groups of American Indians who lived in the Dallas–Ft. Worth and Houston areas at the beginning of Phase I. The same list of consumer concerns was used for the Phase II study to compare results with the original study, issue by issue; however, the list of consumer concerns was different for each metropolitan area (see Methodology section), so the results for the two metropolitan areas are presented separately.

For each issue, the respondent was first asked how important that issue was to them, rating importance on a five-point scale (from 0 to 4). Unless they responded that the issue was not important to them, they were then asked how satisfied they were that the statement about the issue was true, also

Table 18

Services Currently Received

	Dallas–Ft. Worth				Houston			
	Phase I N = 150		Phase II N = 44		Phase I N = 155		Phase II N = 53	
	n	%	n	%	n	%	n	%
Private medical doctor	44	29%	22	50%	74	48%	32	60%
Eye doctor	—		10	23%	41	26%	19	36%
Indian Health Agency	60	40%	15	34%	11	7%	7	13%
Church	14	9%	8	18%	16	10%	22	42%
Medicare/Medicaid	24	16%	12	27%	22	14%	10	19%
Social Security Administration (SSI, SSDI)	21	14%	11	25%	22	14%	8	15%
Indian Center	57	38%	8	18%	4	3%	—	
Indian medicine	14	9%	4	9%	25	16%	10	19%
State Division of Social Services	9	6%	4	9%	18	12%	10	19%
School (i.e., teacher, counselor)	9	6%	4	9%	19	12%	8	15%
County or city health clinic	—		—		15	10%	—	
Other Indian Service Agency	45	30%	2	5%	5	3%	1	2%
Alcohol or substance abuse counseling program	23	15%	2	5%	18	12%	3	6%
Psychologist	6	4%	—		15	10%	—	
State Division of Vocational Rehabilitation	6	4%	4	9%	13	8%	3	6%
Other	10	7%	1	2%	8	5%	6	11%
State job service program	3	2%	1	2%	10	6%	7	13%
Sweat lodge	6	4%	2	5%	11	7%	4	8%
Mental health program	4	3%	2	5%	9	6%	3	6%
Veterans Affairs Administration	6	4%	2	5%	6	4%	1	2%
Senior citizens' program	2	1%	—		4	3%	—	
State Division of Developmental Disabilities	1	1%	—		2	1%	—	
Total	364	2.42	114	2.6	368	2.39	154	2.92

using a five-point scale (from 0 to 4). Thus, relative "problems" were those issues that ranked high in importance but low in satisfaction. Numerically, the average importance of each item was rescaled to range from 0 to 100 by multiplying the average by 25. Similarly, the average satisfaction for each item was rescaled to range from 0 to 100. A measure of dissatisfaction was obtained by subtracting the average satisfaction from 100. The importance and (dis)satisfaction scores were combined by taking their harmonic mean (the square root of importance times dissatisfaction). In this manner, the top-rated problems from the Phase I study could be compared with the Phase II study (Tables 19–22).

Dallas–Ft. Worth. Table 19 shows the top 10 relative problems in the Dallas–Ft. Worth area in descending order of importance in the Phase I study. Table 20 shows the top 10 relative problems in descending order of importance in the Phase II study. Items that are new to the top 10 relative problems are shown in boldface. In general, these problems were not rated as severely by Phase II respondents (problem index range 64–68) as by Phase I respondents (range 67–73). This change seems mainly due to a decrease in the "Importance" ratings of these items (Table 20). This happened to such an extent that the problem index for four items fell out of the top 10 range, making room for four items that had decreased in satisfaction (shown in boldface in Table 20). The net effect of all the changes was a new top-ranking concern: that "social agencies have outreach services to contact all American Indians in the community who have a disability."

Table 19

Top 10 Consumer Concerns, Dallas–Ft. Worth, Phase I

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
1. CC-3. Local media provide education and adequate information for American Indians who have disabilities.	88	80	-8	39	46	+7	73	65	-8
2. CC-11. Affordable health care insurance is available to you.	93	83	-10	48	57	+9	70	60	-10
3. CC-32. Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties of an applicant with a disability.	89	80	-9	46	46	0	69	65	-4
4. CC-36. You know your rights (regarding, for example, housing, employment, social services) as a citizen with a disability.	93	84	-9	49	50	+1	69	65	-4
5. CC-34. Adequate career counseling is available to all American Indians who have a disability.	91	86	-5	48	49	+1	69	66	-3
6. CC-35. Assistive devices (such as wheel chairs, braces, hearing aids, and so on) are available and affordable.	92	84	-8	49	49	+1	69	65	-4

D (difference) % = Phase II – Phase I

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Table 19

Top 10 Consumer Concerns, Dallas–Ft. Worth, Phase I

(continued)

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
7. CC-29. You are aware of housing assistance services in the community.	81	83	+2	43	44	+1	68	68	0
8. CC-33. Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.	89	85	-4	49	45	-4	67	68	+1
9. CC-27. Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	87	76	-11	48	42	-6	67	66	-1
10. CC-19. Quality treatment and prevention programs for alcohol and substance abuse are available for adolescents and other young people.	92	85	-7	51	53	+2	67	63	-4

D% = Phase I – Phase II

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Table 20

Top 10 Consumer Concerns, Dallas–Ft. Worth, Phase II

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
1. CC-17. Social agencies have outreach services to contact all American Indians in the community who have a disability.	88	83	-5	49	43	-6	67	69	+2
2. CC-29. You are aware of housing assistance services in the community.	81	83	+2	43	44	+1	68	68	0
3. CC-33. Special programs to help young people with disabilities make the transition from public school to employment and community living are available and adequate.	89	85	-4	49	45	-4	67	68	+1
4. CC-22. Financial assistance is available to students with disabilities who want to attend college or technical school.	90	85	-5	53	48	-5	65	67	+2
5. CC-28. Affordable housing (both private and public) is available and accessible to residents with all types of disabilities.	90	81	-9	50	45	-5	67	67	0
6. CC-27. Help (like advocates or legal assistance) is available for solving problems with landlords, employers, utility companies, and others.	87	76	-11	48	42	-6	67	66	-1

D% = Phase I – Phase II

Table 20

Top 10 Consumer Concerns, Dallas–Ft. Worth, Phase II

(continued)

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
7. CC-34. Adequate career counseling is available to all American Indians who have a disability.	91	86	-5	48	49	+1	69	66	-3
8. CC-23. Opportunities for adults to learn reading and writing and adequate vocational training or retraining are available.	92	85	-7	55	48	-7	64	66	+2
9. CC-32. Employment agencies and prospective employers focus on the strengths and abilities, rather than the problems and difficulties of an applicant with a disability.	89	80	-9	46	46	0	69	65	-4
10. CC-3. Local media provide education and adequate information for American Indians who have disabilities.	88	80	-8	39	46	+7	73	65	-8

D% = Phase I – Phase II

Houston. The overall importance ratings of all 35 concerns were about the same in the Phase I and II studies. The overall level of satisfaction is a little bit higher among respondents for the Phase II study, but is still very low (29 out of 100), and the difference (5.1) is well within the standard deviation of the responses. Consequently, not too much should be made of this slight increase in overall satisfaction. Because of the increase in overall satisfaction, there is a slight decrease in the overall problem index; however, this difference is also well within one standard deviation, so that nothing can be made of this difference except that three of the Phase I top 10 relative problems dropped out of the top 10 in Phase II and were replaced by three concerns that have been highlighted in boldface (Table 22):

- "Counselors sensitive to the needs of Native Americans with disabilities are available." This concern (CC-27) has increased in importance by 3 points and has decreased in satisfaction by 4 points since Phase I, resulting in a problem index increase of +3.
- "Advocates work in the community to get support for issues benefiting Native Americans with disabilities." This concern (CC-29) has increased in importance (+2) and decreased in satisfaction (–1) since Phase I, resulting in a net increase in the problem index of +2.
- "Utility bills are affordable." This concern (CC-14) has increased a little in both importance and satisfaction, resulting in a net decrease of –1 in the problem index.

At the same time, attitudes about several highly rated concerns in Phase I (Table 21) changed enough to drop out of the top 10 relative problems:

- "Prospective employers and agencies focus on the strengths and abilities, rather than on the problems and limitations of an applicant with a disability." This concern (CC-25) increased +2 in importance but also

increased substantially (+12) in satisfaction, resulting in a net decrease of –6 in the problem index.

- "Good mental health care is available and affordable to Native Americans." This concern (CC-1) increased +3 in importance and increased +12 in satisfaction, resulting in a net decrease of –5 in the problem index.
- "Auto insurance is available to people with disabilities on the same basis as it is to non-disabled people." This concern (CC-33) decreased a small amount (–1) in importance, and increased greatly in satisfaction (+17), resulting in a net decrease of –10 in the problem index. As this difference is more than twice the standard deviation for all concerns, it may be statistically significant.

With these exceptions, the other items in the top 10 relative problems remain about the same in their importance and satisfaction among respondents for both the follow-up study and the original needs assessment.

Table 21

Top 10 Consumer Concerns, Houston, Phase I

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
1. CC-19. Your local government responds to the needs of Native Americans with disabilities.	96	95	-1	14	19	+5	91	88	-3
2. CC-25. Prospective employers and agencies focus on the strengths and abilities, rather than on the problems and limitations of an applicant with a disability.	96	98	+2	14	26	**+12**	91	85	-6
3. CC-20. Native Americans with disabilities are actively involved in directing and operating social programs designed to service them.	96	97	+1	17	20	+3	89	88	-1
4. CC-21. The public recognizes the strengths and conditions of Native Americans in the Houston area.	93	94	+1	14	18	+4	89	88	-1
5. CC-1. Good mental health care is available and affordable to Native Americans.	94	97	+3	16	28	**+12**	89	84	-5
6. CC-30. Information about legal rights and self advocacy is available to Native Americans with disabilities.	95	97	+2	18	16	-2	88	90	+2

D% = Phase I – Phase II

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Table 21

Top 10 Consumer Concerns, Houston, Phase I

(continued)

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
7. CC-35. Financial assistance for examinations and reasonably priced assistive and high-tech devices (wheelchairs, braces, hearing aids, adaptive technology, and so on) are available to Native Americans with disabilities.	96	97	+1	22	24	+2	87	86	-1
8. CC-4. Health care professionals have adequate knowledge of Native American cultures to provide effective and competent health care to Native Americans.	92	96	+4	17	21	+4	87	87	0
9. CC-33. Auto insurance is available to people with disabilities on the same basis as it is to non-disabled people.	92	91	-1	17	38	+17	87	75	-10
10. CC-9. Social service providers have outreach services to contact all American Indians in the community who have a disability.	96	98	+2	21	23	+2	87	87	0
Average - All 35 Concerns	93	94	1.4	24	29	5.1	84	82	-2.2
Standard Deviation - All 35 Concerns	3.9	3.6	2.5	5.7	7.3	5.4	4.07	4.9	3.6

D% = Phase I – Phase II

Table 22

Top 10 Consumer Concerns, Houston, Phase II

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
1. CC-30. Information about legal rights and self advocacy is available to Native Americans with disabilities.	95	97	+2	18	16	-2	88	90	+2
2. CC-20. Native Americans with disabilities are actively involved in directing and operating social programs designed to service them.	96	97	+1	17	20	+3	89	88	-1
3. CC-27. Counselors sensitive to the needs of Native Americans with disabilities are available.	**94**	**97**	**+3**	**24**	**20**	**-4**	**85**	**88**	**+3**
4. CC-19. Your local government responds to the needs of Native Americans with disabilities.	96	95	-1	14	19	+5	91	88	-3
5. CC-21. The public recognizes the strengths and conditions of Native Americans in the Houston area.	93	94	+1	14	18	+4	89	88	-1
6. CC-9. Social service providers have outreach services to contact all American Indians in the community who have a disability.	96	98	+2	21	23	+2	87	87	0

D% = Phase I – Phase II

Table 22

Top 10 Consumer Concerns, Houston, Phase II

(continued)

	Importance			Satisfaction			Problem Index		
	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%	Phase I %	Phase II %	D%
7. CC-4. Health care professionals have adequate knowledge of Native American cultures to provide effective and competent health care to Native Americans.	92	96	+4	17	21	+4	87	87	0
8. CC-29. Advocates work in the community to get support for issues benefiting Native Americans with disabilities.	93	95	+2	22	21	-1	85	87	+2
9. CC-14. Utility bills are affordable.	96	97	+1	21	24	+3	87	86	-1
10. CC-35. Financial assistance for examinations and reasonably priced assistive and high-tech devices (wheelchairs, braces, hearing aids, adaptive technology, and so on) are available to Native Americans with disabilities.	96	97	+1	22	24	+2	87	86	-1
Average - All 35 Concerns	93	94	1.4	24	29	5.1	84	82	-2.2
Standard Deviation - All 35 Concerns	3.9	3.6	2.5	5.7	7.3	5.4	4.07	4.9	3.6

D% = Phase I – Phase II

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Employment Information

Respondents were asked about their work experience (paid or unpaid) and whether they had ever had any problems finding or keeping a job because of certain circumstances. Each question began, "Considering your work experience (paid or unpaid), have you ever had any problems finding or keeping a job because of ..." These are listed for both samples in Table 23, in approximately descending order of importance. Respondents in both metropolitan areas most often cited their disability as an obstacle to finding or keeping a job. Among the least important reasons were ethnicity and English competence. It is striking that most of these problems were reported much more often in Houston than in Dallas–Ft. Worth. Transportation, although not reported as a problem as often as some of the other problems, often comes up in consumer surveys. During the community meeting at the American Indian Center in Euless (between Dallas and Ft. Worth), this problem was raised because the urban public transportation systems do not reach out to Euless.

Table 23

Problems Finding or Keeping a Job

Reason Have you ever had any problems finding or keeping a job because of:	Dallas–Ft. Worth				Houston			
	Phase I N = 150		Phase II N = 44		Phase I N = 155		Phase II N = 53	
	n	%	n	%	n	%	n	%
1. ...your disability?	49	33%	13	30%	60	39%	24	45%
2. ... you don't have the right job skills that are needed?	32	21%	13	30%	45	29%	24	45%
3. ... there are no jobs available where you live?	41	27%	8	18%	39	25%	19	36%
4. ... you don't have enough money to look for work?	33	22%	8	18%	31	20%	22	42%
5. ... employers do not give you a fair chance?	28	19%	5	11%	36	23%	19	36%
6. ... you do not have transportation?	34	23%	5	11%	24	15%	16	30%
7. ... your age?	10	7%	6	14%	36	23%	18	34%
8. ... you don't know the best ways to look for jobs?	16	11%	5	11%	23	15%	20	38%
9. ... you don't know how to best fill out application forms, write a resume, or interview for jobs?	19	13%	5	11%	20	13%	11	21%
10. .... your home responsibilities?	20	13%	4	9%	17	11%	14	26%
11. ... your ethnic background?	24	16%	3	7%	17	11%	9	17%
12. ... your sex?	5	3%	2	5%	27	17%	6	11%
13. ... your English is not good enough to get a job?	5	3%	2	5%	6	4%	3	6%

DISCUSSION AND CONCLUSIONS

It should be noted that the TRC has made a number of initiatives elsewhere in the state to improve services to American Indians with disabilities. Work group meetings of service providers were held in Austin

(August, 1991) and Dallas (April, 1992). Annual meetings of the statewide American Indian Task Force, sponsored by the TRC, were held from 1992 to 1995. Service providers from other agencies and consumers were also invited. The TRC continued its collaboration with Community Health Representatives (CHRs), promoted the employment of American Indians as staff persons within TRC professional positions, trained VR counselors to ask questions regarding American Indian ancestry at the time of application for services, and focused management presentations at the TRC on identifying and improving services to American Indian people. After the Phase I needs assessment in Dallas had been completed, and while the Phase I needs assessment in Houston was being finished, the TRC reported that there had been 11 professional American Indian new hires across the state since 1991, and a 45% increase in the number of individuals served (Jackson, 1993). Additional TRC caseload and expenditure statistics are compiled in Appendix A.

Dallas–Ft. Worth Metroplex

There have been some positive changes in the Dallas–Ft. Worth area. The Dallas Intertribal Center, although it has undergone some changes, still exists at the same location, and continues to provide many services (including an IHS clinic) to the American Indian community. VR referral forms to be used by the Dallas Intertribal Center have been simplified (Jackson, 1993). The American Indian Center has moved and has changed in a number of ways, but continues to provide services. American Indian VR personnel have exhibited increased stability and continuity. Perhaps as a result, the TRC has been able to maintain its role as a lead agency in implementing the recommendations. Specific recommendations of the Phase I study are repeated here with appropriate comments.

1. Representatives of the organizations involved in the needs assessment should meet together to formulate a community action plan to develop strategies to meet the needs of American Indians with disabilities.

A relatively close collaboration has developed between the TRC and the Dallas Intertribal Center, where various employment services are housed. This collaboration needs to be extended to include other American Indian organizations in the metroplex, such as the American Indian Center, the Dallas Indian United Methodist Church, Tribal American Network, Inc., and the Ft. Worth Indian Baptist Mission, as well as agencies with special programs for American Indians, such as the Dallas Independent School District.

2. The availability of general dental services at the Dallas Intertribal Center should be more effectively publicized.

This remains a priority, because dental care is still the top-rated "service needed but not received."

3. Employment services offered by the DIC and the TRC should be coordinated and publicized more effectively.

These services are being coordinated more intentionally, but the effectiveness of these efforts is unknown.

4. An Indian Center is needed to coordinate services for American Indians in Tarrant County.

The move of the American Indian Center from its old location in Grand Prairie (Dallas County) to its new location in Euless (Tarrant County) is clearly a step in the right direction. However, public transportation to this facility is not adequate, and is an impediment to its accessibility to the American Indian community in the Ft. Worth area (west of Euless).

5. Services are needed that are specifically targeted for young American Indians with disabilities, especially in the areas of (a) information and referral services, (b) quality treatment and prevention programs for alcohol and substance abuse, (c) career counseling, (d) special programs to help make the transition from public school to employment and community living, and (e) improved safety and accessibility of public transit systems.

The follow-up study showed a slight increase in satisfaction with treatment and prevention programs for alcohol and substance abuse programs available to young people, along with a decrease in the importance attached to this issue, such that this item dropped off the top 10 list of consumer concerns. The same can be said for career counseling, and although transition services have decreased in importance, they have also decreased in satisfaction. Nevertheless, these last two concerns remain in the top 10.

6. The American Indian media should be utilized more fully (e.g., Indian programs on radio and TV, newsletters, newspapers, information tables, announcements at pow-wows, etc.)

The TRC produced a special brochure and videotape about VR services to American Indians with disabilities, and initiated public service announcements in Dallas via the radio program, "Beyond Bows and Arrows." A videotape about American Indian people was broadcast on Channel 5 (Jackson, 1993). Perhaps as a consequence, there seems to have been some improvement in this area, involving relatively substantial improvement in satisfaction and a decrease in importance. As a result, this dropped from the top concern to the seventh most highly rated concern. The TRC applied this recommendation statewide, with publications on their efforts in the Indian media, including the Houston Inter-Tribal Council, the

American Indian Chamber of Commerce, the Dallas Intertribal Center, and tribal newsletters for Tigua, Alabama–Coushatta, Choctaw, Seminole, Creek, Cherokee, and Chickasaw.

7. Improvements are needed in the availability and affordability of assistive devices.

This has dropped off the list of top-rated concerns as a result of a decrease in importance rating and a small increase in satisfaction.

Houston Metropolitan Area

The situation in Houston has changed since 1993. The Inter-Tribal Council of Houston (ITCH) no longer has the facilities to house the services that were recommended, so that none of the recommendations of the Phase I Houston needs assessment are being implemented at this date. However, respondents for the Houston follow-up study did express a slightly higher level of satisfaction across all 35 consumer concerns, but this increase is small and probably not statistically significant. Three key areas show signs of improvement:

- "Prospective employers and agencies focus on the strengths and abilities, rather than on the problems and limitations of an applicant with a disability." This concern (CC-25) increased +2 in importance but also increased substantially (+12) in satisfaction, resulting in a net decrease of –6 in the problem index.
- "Good mental health care is available and affordable to Native Americans." This concern (CC-1) increased +3 in importance and increased +12 in satisfaction, resulting in a net decrease of –5 in the problem index.
- "Auto insurance is available to people with disabilities on the same basis as it is to non-disabled people." This concern (CC-33) decreased a small

amount (–1) in importance, and increased greatly in satisfaction (+17), resulting in a net decrease of –10 in the problem index. Since this difference is more than twice the standard deviation for all concerns, it may be statistically significant.

The reasons for these three positive changes remain to be established. They could be merely the result of a different sample of respondents, or there may have been changes in services in the Houston area that have addressed the concerns expressed in Phase I.

Based on the data from this follow-up study, each recommendation from the original study is reviewed here.

1. An eye/vision clinic is needed at the Inter-Tribal Council of Houston (ITCH) one or two days per week.

The follow-up study provides evidence that this clearly established need remains to be addressed. Vision and eye care remains one of the services most needed but not received (42% of Phase I respondents, 43% of Phase II respondents).

2. A mental health clinic is needed at the ITCH one or two days per week.

Although this recommendation is not being implemented, the need for it seems to have decreased a little in that "Good mental health care is available and affordable to Native Americans," Consumer Concern CC-1, has dropped from the top 10 relative problems as a result of an increase in satisfaction. It may be that other means of providing this service have been found.

3. Vocational rehabilitation and job counseling services should be continued weekly at regularly scheduled times at the ITCH.

The need for this service has increased. Among the consumer concerns, the top 10 relative problems now include "Counselors sensitive to the needs of Native Americans with disabilities are available" (CC-27). This change

correlates with the transfer of Richard Yahola (Muscogee) as VR counselor, and the difficulty of recruiting an American Indian VR counselor to serve the Houston metropolitan area. In addition, Phase II respondents had, if anything, more problems finding or keeping a job than the respondents in the original study.

4. A public advocacy position is needed at the ITCH.

The need for this service has increased. Among the consumer concerns, the top 10 relative problems now include a new item, "Advocates work in the community to get support for issues benefiting Native Americans with disabilities" (CC-29).

The location of these services requires special attention, as the ITCH no longer has facilities available for this purpose. A common location is most desirable, because of the benefits of synergy (mutual referral and interaction), name recognition, sharing of overhead expenses, and so forth. It would be helpful if a facility could be shared by the ITCH, the Alabama–Coushatta Employment and Training office, the Cherokee Cultural Society, the American Indian Chamber of Commerce, and other American Indian organizations. This would benefit all of these organizations, and would enhance the visibility of the recommended services in the American Indian community.

TRC American Indian Accomplishments

TRC statistics relating to American Indians in this decade are summarized in Appendix A. Although these statistics are not complete, they show, in general, greater progress in hiring new American Indian personnel and VR services to American Indians with disabilities from 1991 to 1995. These statistics may be summarized as follows:

Texas Rehabilitation Commission	Peak Fiscal Year
• New American Indian hires (5)	1991
• Applicants who identified themselves as American Indian (44)	1993
• Active caseload, Dallas–Ft. Worth and Houston regions (298)	1994
• American Indian staff (16)	1994
• Active cases (494)	1995
• Status 26 number of clients closed (316)	1995
• Status 26 expenditures ($1,067,377)	1995
• Funds spent on active cases ($721,182)	1997

"Peak Fiscal Year" means the year for which the indicated variable reached a maximum. These statistics also show that most of the favorable indicators peaked in 1995. Only one favorable indicator continued to grow: Funds spent on active cases. But the number of active cases, the number of clients closed in status 26 (rehabilitated), and the expenditures on status 26 cases all peaked in 1995, and the number of applicants who identified themselves as American Indians peaked some years earlier in 1993.

At about the same time, the TRC's statewide American Indian Task Force decided at their meeting on May 4, 1994, to develop local task force groups in Dallas–Ft. Worth, Houston, Corpus Christi, Austin, Lubbock, El Paso, San Antonio, East Texas, and Eagle Pass/Bracketville/Del Rio.

The next year at the October 11, 1995 meeting of the statewide American Indian Task Force, these local task forces presented their goals for the coming year, which indicated that they would carry the burden of planning and implementing services to American Indians with disabilities and there would be no further need for statewide meetings on this subject. Thus, 6 months

later, Joellen Flores Simmons wrote that "As a result we now have also regionalized the services, so there is not a special state program for American Indians, but a larger activity that includes all diverse areas" (Appendix C).

The statistics in Appendix A, while far from conclusive, suggest that the gains made by the TRC in improved services to American Indians from 1991 to 1995 are now in danger of being lost. Whether or not this is related to the decision to abandon the special state program for American Indians is not clear. However, it may be that a few more years of statewide attention are needed to consolidate the gains made from 1991 to 1995. We cannot yet assume that the issue of services to American Indians with disabilities in Texas has been "solved."

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Appendix A

THE TRC AMERICAN INDIAN PROJECT

Applicants who identified themselves as American Indian

Region Number	Region Name	FY'91	FY'92	FY'93	FY'94*
I	Lubbock	3	5	9	1
II	(Dallas–) Ft. Worth	1	2	6	4
III	Austin	0	0	3	4
CO	Austin HQ	3	5	11	4
DDS	Austin HQ	3	6	1	0
IV	Houston	2	4	2	4
V	San Antonio	2	2	7	2
VI	Dallas	4	7	5	
Total	Statewide	16	27	44	19

*FY'94 based on 9/1/93 – 2/28/94 (6 months)

Active Cases By Region

Region	FY'90	FY'91	FY'92	FY'93	FY'94	FY'95	FY'96	FY'97 (4/30)
II: DFW	47		157		199 (41%)	170	152	176
IV:Houston	6		64		99 (20%)	101	70	71
Others	34		97		190 (39%)	223	202	219
Total	87	214	318	409	488 (100%)	494	424	466

Funds spent on Active Cases, by Region

Region	FY'91	FY'92	FY'93	FY'94	FY'95	FY'96	FY'97 (4/30)
II: DFW		$245,183			$259,194	$272,365	282,459
IV:Houston		$48,920			147,198	157,031	164,472
Others		$225,651			223,535	229,464	274,251
Total	$218,478	$519,754	$573,420	$579,791	$629,927	$658,860	$721,182

Status 26 Number of Clients Closed

Region	FY'91	FY'92	FY'93	FY'94	FY'95	FY'96	FY'97 (4/30)
II: DFW				50%*	147	66	33
IV: Houston				10%*	47	28	14
Others				40%*	122	58	41
Total Status 08	57	88	120	124*		64	44
Total Status 26	72	74	127	160	316	152	88
Total Status 28	35	70	85	123*		118	50
All closures	166	233	335	407	784	378	204
% Status 26	43%	32%	38%	39%	40%	40%	43%

*Estimate based on totals through 3/31/94

Status 26 Expenditures by Region

Region	FY'91	FY'92	FY'93	FY'94	FY'95	FY'96
II: DFW		$86,581		$74,319*	$318,494	$204,926
IV: Houston		$10,139		$17,348*	$ 95,025	$99,380
Others		$82,553		$82,614*	$309,857	$162,242
Expenditures (Status 26 only)	$104,046	$179,273	$371,811	$174,281* ($410,887)	$723,376	$466,548
Expenditures (All closed cases)	$143,686	$285,229	$566,803	$598,950	$1,067,377	

*Through 3/31/94

Active Caseload by status, FY 1994 Thru 3/31/94

Region	02	10	14–20	22–24	Total
II: DFW	21	15	122	40	198
IV: Houston	24	11	58	5	98
Others	33	32	92	29	186
Total Active	78	58	272	74	482
% Status	16%	12%	56%	15%	100%

Region II (D/FW) Active Caseload by Status

Fiscal Year	02	10	14–20	22–24	Total
1994	21	15	122	40	198
1995	9	11	122	28	170
1996	11	14	99	28	152
1997 (4/30)	19	12	115	30	176

Region IV (Houston) Active Caseload by Status

Fiscal Year	02	10	14–20	22–24	Total
1994	24	11	58	5	98
1995	15	5	59	16	95
1996	11	6	42	11	70
1997 (4/30)	8	9	43	11	71

All Closures by status, FY 1994 Thru 3/31/94

Region	08	26	28	30	Total	FY 1994 Expenditures
II: DFW	23	41	28	7	99	$113,464
IV: Houston	9	8	6	0	23	$22,754
Others	17	33	15	5	70	$123,817
Total closures	49	82	49	12	192	$260,035
% Status	26%	43%	26%	6%	101%	

Employment Data

American Indian Employees (as of 3/31/94), by Salary Group

Region	6	7	9	10	11	15	16	18	19	Total
II: DFW					1		2			3
IV: Houston					1		2			3
Others	1	1	1	1	2	2		1	1	10
Total (3/31/94)	1	1	1	1	4	2	4	1	1	16

Classification – Title by Salary Group (Statewide)

Salary Group	Classification – Title	1991	1992	1993	1994
20	Staff Services Officer IV	1	1		
19	Planner II				1
18	Program Specialist I				1
17	Planner I	1	1	1	
16	V.R. Counselor II	3	5	5	4
15	V.R. Counselor I/		1	1	2
	Admin Tech IV	1	1	1	
11	Rehab. Services Tech. III/	1	1	2	4
	Research Assistant			1	
10	Accounting Clerk IV				1
9	Rehab. Services Tech. II	1	1	1	1
8	Accounting Clerk III	1	1	1	
7	Rehab. Services Tech. I	2	3	2	1
6	Accounting Clerk II			1	1
Total	All positions	11	15	16	16

New Hires

Salary Group	Classification – Title	FY'91	FY'92	FY'93	FY'94
20	Staff Services Officer IV				
19	Planner II				
18	Program Specialist I				
17	Planner I				
16	V.R. Counselor II	2			
15	V.R. Counselor I/ Admin Tech IV	1	2	1	2
11	Rehab. Services Tech. III/ Research Assistant			2	1
10	Accounting Clerk IV				
9	Rehab. Services Tech. II				
8	Accounting Clerk III				
7	Rehab. Services Tech. I	2			
6	Accounting Clerk II		1		
Total	All positions	5	3	3	3

Sources

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Duarte, J. A. (1997, June 12). Texas Rehabilitation Commission, Fax.

Jackson, J. L. (1993, May). *American Indians in Texas*. Paper presented at a meeting of the American Indian Rehabilitation Research and Training Center, Institute for Human Development, Northern Arizona University, Flagstaff, AZ.

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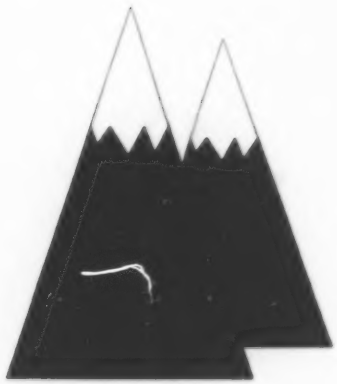
Ward, R. (1995). Texas Rehabilitation Commission, American Indian Project Statistics. Presentation to American Indian Task Force.

Appendix B

AMERICAN INDIAN PROJECT:
ACTION PLANS AND ACCOMPLISHMENTS SUMMARY

AMERICAN INDIAN PROJECT

ACTION PLANS AND ACCOMPLISHMENTS SUMMARY



AMERICAN INDIAN PROJECT
1991 DALLAS CONFERENCE

- **ACTION PLAN:**

  Use media to increase public awareness.

  Educate special interest groups and other VR agencies.

- **ACCOMPLISHMENTS:**

  Major cities' local TV channels have aired PSAs on TRC's providing services to American Indians with disabilities.

  TRC has ongoing educational efforts to other VR and health service agencies.

AMERICAN INDIAN PROJECT
1991 DALLAS CONFERENCE

- **ACTION PLAN:**

  TRC to develop a video tape for community information.

  TRC brochure on services available to American Indians.

- **ACCOMPLISHMENTS:**

  TRC has completed video taping for community information.

  TRC brochure developed: ***Are You A Native American Living in Texas?***

AMERICAN INDIAN PROJECT
1991 DALLAS CONFERENCE

- **ACTION PLAN:**

  TRC work group members assigned to disseminate and share information.

- **ACCOMPLISHMENT:**

  Work group members assigned to each Reservation and Intertribal Council.

AMERICAN INDIAN PROJECT
1992 HOUSTON CONFERENCE

- **ACTION PLAN:**

  Print in Spanish or native language where possible the TRC American Indian brochure.

  Expand American Indian participation in work group.

- **ACCOMPLISHMENTS:**

  TRC American Indian brochure is being translated to Spanish, reviewed and scheduled for printing.

  Work group has nominated two participants.

AMERICAN INDIAN PROJECT
1992 HOUSTON CONFERENCE

- ACTION PLAN:

Expand TRC video to focus on female American Indian with a physical disability.

- ACCOMPLISHMENT:

Female American Indian has been selected and is being scheduled for taping.

AMERICAN INDIAN PROJECT
1992 HOUSTON CONFERENCE

- ACTION PLAN:

Develop a Master Resource Guide, listing service providers and/or American Indian organizations.

- ACCOMPLISHMENT:

TRC has developed, updated and disseminated a Master Resource Guide, listing service providers and/or American Indian organizations.

AMERICAN INDIAN PROJECT
1993 DALLAS CONFERENCE

- ACTION PLAN:

Develop marketing strategy and training packet to disseminate information to Coastal Bend and San Antonio Intertribal Councils and the Bracketville and Laredo areas.

- ACCOMPLISHMENT:

TRC training packet was developed and has been presented in Corpus Christi Coastal Bend and to Austin area Intertribal Council.

AMERICAN INDIAN PROJECT
1993 DALLAS CONFERENCE

- ACTION PLAN:

Agreement between TRC and Oklahoma VR.

Report project and accomplishments to *TRC Today*.

- ACCOMPLISHMENTS:

Dallas and Fort Worth visit Oklahoma and signed an agreement.

American Indian project article published in *TRC Today*, February 1994.

AMERICAN INDIAN PROJECT 1993 DALLAS CONFERENCE

- **ACTION PLAN:**

  Develop quarterly activity calendar with Human Resource Department.

- **ACCOMPLISHMENT:**

  Promoted ***MORNING STAR*** Newsletter, published by the American Indian Center of Dallas, which has a scheduled calendar of events section.

AMERICAN INDIAN PROJECT 1993 EL PASO CONFERENCE

- **ACTION PLAN:**

  Translation of TRC Brochure, ***Are You A Native American Living in Texas?*** into Kickapoo Indian language.

- **ACCOMPLISHMENT:**

  Completed translation into the Kickapoo Indian language; brochure ready for review and printing.

AMERICAN INDIAN PROJECT 1993 EL PASO CONFERENCE

- **ACTION PLAN:**

  Complete *Needs Assessment of American Indians with Disabilities in the Dallas-Fort Worth Area* by Northern Arizona University.

- **ACCOMPLISHMENTS:**

  Needs Assessment from Dallas-Fort Worth paper completed; results from *Houston Needs Assessment* project disseminated with help of University of Houston School of Optometry at spring powwow.

AMERICAN INDIAN PROJECT RECENT ACCOMPLISHMENTS

- Interfaced with Richard Fleager of El Paso Natural Gas Company to provide 5 computers to the Tigua Indian Education Department.

- Completed American Indian counselor dialogue video and project's goals and overview informational video.

AMERICAN INDIAN PROJECT RECENT ACCOMPLISHMENTS

- Contact made to promote liaison with the National Association of Deaf Native Americans (NADNA).
- Arrangements for cultural diversity speakers at the annual TRA conference.
- Membership in and attendance at Minority Health Issues workshops for awareness of minority health needs.

Appendix C

STATEMENT OF JOELLEN FLORES SIMMONS

DEPUTY COMMISSIONER, TEXAS REHABILITATION COMMISSION

Statement of Joellen Flores Simmons

Deputy Commissioner, Texas Rehabilitation Commission

April 24 & 29, 1996

Due to the earlier work with your [AIRRTC] grants, TRC now has a special activity in our strategic plan regarding diversity. Of course it was due to the American Indian Program focus that we began to get focused, and we now have moved into other groups. As a result we now have also regionalized the services, so there is not a special state program for American Indians, but a larger activity that includes all diverse areas.

Actually it occurred as a result of our strategic planning required of agencies, in which the regional directors and my board, realized we were/had made progress on our statewide outcomes as far as TRC, and that we needed to address the population as part of our cultural diversity training, which was another project from the RCEP/RSA.

Another issue quite frankly was that all state agencies have been given no growth for staff and when any employees left, we did not rehire. WE did NOT delete any staff who was on board, except a half-time person who was in Dallas. We have assigned the program to current staff, if employees left. We have some very devoted staff to this population. We did have staff in many programs, who because they left did not get replaced, in several programs. We had to meet certain targets of FTE levels, and the manner in which we will continue the program, without special targeted FTEs, is through our cultural diversity training for all staff.

We will be reviewing statistics of clients of minority populations in relation to staff ethnicity, in order to plan for all minority populations. We will have to train our staff on how to work with people of all diversities. We will continue to use the resources developed and package them for the training. JA will continue to monitor the end of years stats and reports them to me, as a matter of information, but we will not be setting state targets, but will have regional focus. Unfortunately we have no choice in our FTE targets, which are required of all state agencies. We did not rehire in many state programs, and even had to regroup in the VR area. We therefore have each region focusing on what they need to do with the American Indian population, rather than a statewide meeting. This allows more focus from a regional perspective, but unfortunately does not give the ability to hire more staff, if they leave.

You will need to work with J. Duarte to see where we have specific persons working with the American Indians. I think the Kickapoo area is the only area left with the old concept of hiring someone who is an Indian to work with the reservations. Otherwise current staff added this to their responsibility.

Another problem we had was politics with the reservations when the governors turned over, they refused to work in some areas with staff we had hired who were aligned with a previous governor or chief. Suggest you talk to Mary Valentini about that problem, as hers was most of an issue. As I say, we are still very interested in this population, but do not have the resources to devote them to targeting this population alone. The RSA will be gathering statistics on all minority areas.

I also have had to cut back on most project areas to focus on REENGINEERING, which is a priority of VR agencies, nationwide. I do not

expect to have special projects for extra focus, beyond your current contracts. This is a real downer for us all because we have become very loyal to this special population and do not want to appear to no longer have the desire to continue to support our clients who identify more easily with a person from their own background. We just do not have the authority to grow as we once did.